

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03734

3751 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------------|--|---|--|---|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Inigoes | | c. LENGTH OF STAY IN 1b RURAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Inigoes | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | d. STREET ADDRESS Rural | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Elizabeth | | First | Middle | Lost | 4. DATE OF DEATH March 2 1958 | Month | Day Year |
| 5. SEX female | | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 27, 1875 | 9. AGE (In years lost birthday) 82 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Medical | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard M. Abell | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Sutton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Richard M. Smith - St. Inigoes, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary sclerosis | | DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour o. n. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Great Mills, Md. | (County) | (State) | |
| 21. I certify that I attended the deceased from April 1, 1950 , to Mar 1 1958 , that I last saw the deceased alive on March 1, 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE P.J. Bean PHYSICIAN'S NAME (Type) P.J. Bean, MD | | ADDRESS (Street, city or town, state) Great Mills, Md. | | DATE SIGNED 3/3/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/4/58 | 22c. NAME OF CEMETERY OR CREMATORIAL Trinity Episcopal | 22d. LOCATION (City, town, or county) St. Marys City, Md. | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | ADDRESS | 24a. REC'D BY REGISTRAR DATE MAR 6 '58 | 24b. REGISTRAR'S SIGNATURE Douglas J. L. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WELFARE STATE GOVERNMENT OF NEVADA - GALLIVAN BLDG.

CERTIFICATE OF DEATH

BUREAU V.

MAR 6 1968

RECEIVED

1
12
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03735

3752

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|--|---|---|---|--|---|--------------------------|---|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Leonardtown | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hosp. | | | | e. STREET ADDRESS Rural | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Thomas | | First | Middle | Lost | 4. DATE OF DEATH March 7 1958 | Month | Day | Year |
| 5. SEX male | | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Jan, 21, 1935 | 9. AGE (In years from birthday) 23 yrs. | IF UNDER 1YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Clarence M. Aud | | | | 14. MOTHER'S MAIDEN NAME Estelle Combs | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 816X | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Clarence M. Aud- Great Mills, Md. | | Address | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816X | | Crushing Injury of Chest | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min. | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | | |
| DUE TO | | | | | | | | |
| (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Lost control of auto & crashed into 3 other automo- biles going north on Rt: # 5 | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Rt: #5 Morganza, St. Marys, Md. | | 20f. (City or town) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Hour 9:45 p.m. | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Rt: #5 Morganza, St. Marys, Md. | | (County) (State) | | |
| 1958 | | of work <input type="checkbox"/> | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>Ronald Boyd</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 3/7/58 | | | | |
| EXAMINER'S NAME (Type) P.B. Robinson - Leonardtown, Md. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/11/58 | | 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Holy Face | | 22d. LOCATION (City, town, or county) Great Mills, Md. | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | | | 24a. REC'D BY REGISTRAR DATE MAR 13 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Robert E. ...</i> | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MATERIALS FOR DENTAL EXAMINATION—SAVINGS

BUREAU V.

MAY 23 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3753

CERTIFICATE OF DEATH

Reg. Dist. No. 3736

| | | | | | | | |
|---|----------------------------------|---|--|---|-------------------------------------|--|-------------|
| 1. PLACE OF DEATH a. COUNTY St. Marys | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements | | c. LENGTH OF STAY IN 1b RURAL | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville. | | d. STREET ADDRESS Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William | | First Alfred | Middle Bowles | Last March | DATE OF DEATH Month 6 | Month 1958 | Doy Year |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH Jan. 3, 1866 | 9. AGE (In years lost birthday) 92 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm owner | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Daniel Bowles | | | | 14. MOTHER'S MAIDEN NAME Priscilla Graves | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Fred Bowles - Loveville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x | | DUE TO Generalized arteriosclerosis cerebral thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. s. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) Mechanicsville | (County) Prince George's Co. | (State) Md. | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, at _____, from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) Mechanicsville, Md. | | DATE SIGNED 3/7/58 | |
| ACTUAL SIGNATURE J. Roy Guyther | | | | | | | |
| PHYSICIAN'S NAME (Type) J. Roy Guyther, MD | | | | | | | |
| 22o. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/10/58 | 22c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cem. | 22d. LOCATION (City, town, or county) Morganza, Md. | | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Rohinson, - Leonardtown, Md. | | ADDRESS Leonardtown, Md. | 24a. REC'D BY REGISTRAR MAR 13 58 | 24b. REGISTRAR'S SIGNATURE John Rohinson | | | |
| | | | DATE | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HAZARD-CALIMORE 16

CERTIFICATE OF DEATH

MAR 13 1968

RECEIVED
BUREAU Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03737

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| St. Marys MARYLAND | | a. STATE Maryland b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Leonardtown | | X Patuxent River | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| St. Marys Hospital | | US Naval Air Station | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

| | | | | | | | |
|--|-------|----------|------|------------------|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| George | Allie | Caldwell | | March | 9 | | 1958 |

| | | | | | | |
|--------|------------------|---|------------------|---------------------------------|-----------------|------------------|
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| male | white | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | April 11, 1918 | 39 yrs. | Months | Days |

| | | | |
|---|-----------------------------------|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Supply Service | Warehouse | West Virginia | USA |

| | |
|-------------------|--------------------------|
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| Frank B. Caldwell | Nellie R. Furry |

| | | |
|---|-------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
| | | Adm. US NAS |
| | | Frank B. Caldwell - Patuxent River, Md. |

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823x DUE TO | | Fracture 2 Skull 5 hrs |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO | | |
| (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | |
| NONE | | |

| | | | |
|--|--|--|---|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran off road while proceeding north on Route #5 & hit tree | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|--|---|

| | | | | | |
|--|---|---|-------------------------------|----------------------|---------|
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 1:15 3-9 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STATE HIGHWAY #5 | 20f. (City or town) Park Hall | (County) At Marys Md | (State) |
|--|---|---|-------------------------------|----------------------|---------|

| | | | | | |
|--|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
|--|--|--|--|--|--|

| | | | |
|---|--|--|--|
| ACTUAL SIGNATURE <i>W.D. Boyd</i> | DATE SIGNED 3/9/58 | | |
| EXAMINER'S NAME (Type) William D. Boyd, MD | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |

| | | | |
|--|------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 22b. DATE THEREOF 3/11/58 | 22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill, West Va. | 22d. LOCATION (City, town, or county) West Virginia |
|--|------------------------------|--|--|

| | | | |
|--|---------|--|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE MAR 13 '58 | 24b. REGISTRAR'S SIGNATURE <i>A. Lewis</i> |
|--|---------|--|---|

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINERS & CEREMONY OF DEATH

BUREAU V. S.

MAR 13 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3755
CERTIFICATE OF DEATH

Reg. Dist. No. **03738**

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Marys | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN 1b Leonardtown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Bessie | Middle May | Last Cox |
| 4. DATE OF DEATH | Month March | Day 22 | Year 1958 |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 27, 1883 |
| 9. AGE (In years lost birthday) 74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 11. KIND OF BUSINESS OR INDUSTRY domestic | 12. BIRTHPLACE (State or foreign country) Missouri |
| 13. FATHER'S NAME John W. Cornelius | 14. MOTHER'S MAIDEN NAME ? Russell | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | |
| 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Margie Milstead - Leonardtown, Md. | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 17ox | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma left breast | | 3 years | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. p. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Dec 8, 1957 , to March 22, 1958 , that I last saw the deceased alive on March 22, 1958 , and that death occurred at 2 p.m. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>P. J. Bean</i> | M.D. | | ADDRESS (Street, city or town, state) Great Mills, Md. DATE SIGNED 3/23/58 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 3/23/58 | 22c. NAME OF CEMETERY OR CREMATORIAL Hamilton, Missouri |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | 24a. REC'D BY REGISTRAR MAR 26 '58 | 24b. REGISTRAR'S SIGNATURE <i>P. B. Robinson</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 29 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03739

| | | | | | | |
|---|--|--|--|---|--|--------------------|
| 1. PLACE OF DEATH a. COUNTY | | 3756 St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b Leonardtown D.O.A. | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drayden | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. STREET ADDRESS | | f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| St. Mary's Hospital | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First James | Middle Eugene | Last Dent | 4. DATE OF DEATH Month March Day 2 Year 1958 | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | B. DATE OF BIRTH Oct. 25. 1898 | 9. AGE (In years last birthday) 59 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY General Store | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 13. FATHER'S NAME James Wilson Dent | | 14. MOTHER'S MAIDEN NAME Mary Q. Combs | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 217-329145 | | 17. INFORMANT Benjamin E. Dent Address Drayden. Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | Coronary occlusion | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) | | | | | | |
| (c) DUE TO | | | | | | |
| (d) DUE TO | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | None | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year 5:45 a.m. 3. 29. 58 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 3/2/58 |
| EXAMINER'S NAME (Type) | | William D. Boyd. M.D. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/5/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln | | |
| 22d. LOCATION (City, town, or county) (State) 3201 Bladensburg Rd. Md. | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers | | ADDRESS Washington D.C. | | 24a. REC'D BY REGISTRAR DATE MAR 5 '58 | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Albert Beach | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

THE CLOTHES EXAMINER'S CERTIFICATE OF TEST

MAR 5 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3757

CERTIFICATE OF DEATH

Reg. Dist. No.

03740

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY ST MARY'S | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DRAYDEN RURAL LIFE | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X DRAYDEN RURAL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | d. STREET ADDRESS — | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First MARY | Middle O | Last DENT |
| 4. DATE OF DEATH | Month MARCH | Day 5 | Year 1958 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-23-1874 |
| 9. AGE (In years last birthday) 83 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | 11. KIND OF BUSINESS OR INDUSTRY STORE KEEPER ST MARY'S, CO. MD | 12. BIRTHPLACE (State or foreign country) USA |
| 13. FATHER'S NAME MARTIN E. COMBS | 14. MOTHER'S MAIDEN NAME SARAH FENHAGEN | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT BENJAMIN R DENT | Address DRAYDEN MD |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MYOCARDITIS GENERALIZED ARTERIOSCLEROSIS 10 years. | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan 1, 1954 to Mar 5, 1958 that I last saw the deceased alive on Mar 5, 1958 , and that death occurred at 10:55 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W.H. Patrick | ADDRESS (Street, city or town, state) Lexington Park Md. 3-5-58 | | |
| PHYSICIAN'S NAME (Type) W.H. PATRICK M.D. | DATE SIGNED 3-5-58 | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 3-6-58 | 22c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN | 22d. LOCATION (City, town, or county) (State) BLADENSBURG MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO | ADDRESS 3072 MST N.W. | 24a. REC'D BY REGISTRAR DATE MAR 7 '58 | 24b. REGISTRAR'S SIGNATURE W. Chambers |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

03741

| | | | | | | | | | |
|---|--|--|--|---|--|--|---|------|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Frances | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 20, 1868 | 9. AGE (In years 90 at birthday) yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | 10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William F. Greenwell | | 14. MOTHER'S MAIDEN NAME Sarah Matilda Floyd | | Address | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Bronchial cold. DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) age - | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from March 25, 1958 to March 26, 1958 that I last saw the deceased alive on March 26, 1958 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE Charles Greenwell M.D. | | ADDRESS (Street, city or town, state) Leonardtown Md. | | DATE SIGNED March 31, 1958 | | | | | |
| PHYSICIAN'S NAME (Type) Charles Greenwell M.D. | | Leonardtown, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/29/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. John's | | 22d. LOCATION (City, town, or county) Hollywood, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 31 '58 | | 24b. REGISTRAR'S SIGNATURE Alvarez | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 31 1993

DEGEIA ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3759

CERTIFICATE OF DEATH

03742

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|-------------------------------------|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | | c. LENGTH OF STAY IN lb 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First John | Middle Joseph | Last Greenwell | 4. DATE OF DEATH | Month March | Day 12 | Year 1958 |
| S. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 25, 1878 | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR yrs. 2 | IF UNDER 24 HRS. Months 15 | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Spaulding Greenwell | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Spaulding | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Grace E. Greenwell | | Address Hollywood, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42212 DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sensibility DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 10 , 1958, to Mar 12 , 1958, that I last saw the deceased alive on Mar 6, 1958 , and that death occurred at 7A M , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles Greenwell | | M.D. | | ADDRESS (Street, city or town, state) Leonardtown | | DATE SIGNED 22d | |
| PHYSICIAN'S NAME (Type) Charles Greenwell M.D. | | Leonardtown, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/15/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. John's | | 22d. LOCATION (City, town, or county) (State) Hollywood, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE MART 14 1958 | | 24b. REGISTRAR'S SIGNATURE W. Clarke | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF SEAFARERS-ALUMNI

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3760

CERTIFICATE OF DEATH

Reg. Dist. No. 03743

| | | | | | | | |
|--|--|--|---|--|---------------------------------------|---|----------------------|
| 1. PLACE OF DEATH o. COUNTY St. Marys | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park, | | c. LENGTH OF STAY IN 1b Rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lexington Park | | d. STREET ADDRESS Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First James | Middle William | Last Jerdon | 4. DATE OF DEATH | Month March | Day 18 | Year 19 58 |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Jan. 4, 1958 | 9. AGE (In years last birthday) yrs. 2 | IF UNDER 1 YEAR Months 2 | IF UNDER 24 HRS. Days 14 | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Jerdon | | 14. MOTHER'S MAIDEN NAME Agnes Bennett | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Thomas Jerdon - Lexington Park, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X | | DUE TO Bronchitis Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 1 week | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from Mar. 17, 1958 to Mar. 18, 1958 that I last saw the deceased alive on Mar. 18, 1958 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) Lexington Park, Md. | | DATE SIGNED 3-18-58 | |
| ACTUAL SIGNATURE H.W. Patrick | PHYSICIAN'S NAME (Type) William H. Patrick, MD | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/19/58 | 22c. NAME OF CEMETERY OR CREMATORIAL Holy Face Cemetery | 22d. LOCATION (City, town, or county) (State) Great Mills, Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md. | | ADDRESS Leonardtown, Md. | 24a. REG. NO. 1234567890 | 24b. REGISTRAR'S SIGNATURE W.H. Patrick | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
MAR 26 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No 03744

3761

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood | | c. LENGTH OF STAY IN 1b 20 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | | | |
|---|------------------------|--------------------------|------|---|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) | First Ernest | Middle Lathoum | Last | 4. DATE OF DEATH March 10, 1958 | Month | Day | Year |
|---|------------------------|--------------------------|------|---|-------|-----|------|

| | | | | | | | |
|-----------------------|----------------------------------|---|---------------------------------|---|---------------------------------------|---------------------------------------|------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1892 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Hours 0 | Min. 0 |
|-----------------------|----------------------------------|---|---------------------------------|---|---------------------------------------|---------------------------------------|------------------|

| | | | |
|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|-----------------------------------|--|---|

| | |
|-------------------------------------|--|
| 13. FATHER'S NAME Unknown | 14. MOTHER'S MAIDEN NAME Unknown |
|-------------------------------------|--|

| | | | |
|---|--|--|---------------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Philip E. Clarke | Address Hollywood, Maryland |
|---|--|--|---------------------------------------|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 1 hr |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | Coronary occlusion |

| | | |
|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|--|

| | | |
|--|--|--|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
|--|--|--|

| | | | | |
|---|------------------------|---|--|--|
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|------------------------|---|--|--|

| | | | | | |
|---|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
|---|--|--|--|--|--|

| | | |
|--|--|-------------------------------|
| ACTUAL SIGNATURE <i>Wind Bayl</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED 3/10/58 |
| EXAMINER'S NAME (Type) Wind Bayl | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |

| | | | |
|---|-------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 2/13/58 | 22c. NAME OF CEMETERY OR CREMATORIUM St. John's | 22d. LOCATION (City, town, or county) Hollywood, (State) Md. |
|---|-------------------------------------|---|--|

| | | | |
|--|---------|--|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md. | ADDRESS | 24a. REC'D BY REGISTRAR DATE 11-58 | 24b. REGISTRAR'S SIGNATURE <i>Well said!</i> |
|--|---------|--|---|

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MISSOURI STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

MAR 11 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3762

CERTIFICATE OF DEATH

Reg. Dist. No. 03745

| | | | | |
|---|--------------------------------------|---|---|--|
| 1. PLACE OF DEATH o. COUNTY St. Mary's | | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE New York b. COUNTY Queens St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River | | c. LENGTH OF STAY IN lb 24 Minutes | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York PATUXENT RIVER | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Station Hospital USNAS | | d. STREET ADDRESS 163 CHINNICK | 3411 203rd St., Bay Side | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) | First Bernadette | Middle (N) | Last LENNON | 4. DATE OF DEATH March 31 1958 |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 31 March 1958 | 9. AGE (In years lost birthday) yrs. 24 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Owen Thomas LENNON | | 14. MOTHER'S MAIDEN NAME Patricia Ann TAIT | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Official US Navy Records. Address USNAS Patuxent River, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Prematurity DUE TO (c) | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 24 Min | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 31 March 1958 , to 31 March 1958 , that I last saw the deceased alive on 31 March 1958 , and that death occurred at 4:44 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE P. T. O'REGAN , LT MC USNR M.D. ADDRESS (Street, city or town, state) 4-1-58 DATE SIGNED 4-1-58 | | | | |
| PHYSICIAN'S NAME (Type) P. T. O'REGAN, LT MC USNR Station Hospital USNAS Patuxent River, Md. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4-1-58 | 22c. NAME OF CEMETERY OR CREMATORIUM Holy Face Cemetery | 22d. LOCATION (City, town, or county) Great Mills, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Station Hospital, USNAS, Patuxent River, Md. | | ADDRESS | 24a. REC'D BY REGISTRAR DATE APR 3 '58 | |
| | | | 24b. REGISTRAR'S SIGNATURE G. W. Edwards | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HOMELAND SECURITY - BALTIMORE

CERTIFICATE OF DEATH

31

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PR 3 1959

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03747

3763

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY St. Mary's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements | |
| f. STREET ADDRESS | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Darlene | | 4. DATE OF DEATH Month March Day 24, Year 1958 | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 2, 1957 | |
| 9. AGE (in years lost birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months 22 Hours 22 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Bowman | | 14. MOTHER'S MAIDEN NAME Genevieve Queen | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Genevieve Queen Clements, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bronchitis pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? Hydrocephalus YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Wm D. Boyd | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) William D. Boyd M.D. | | DATE SIGNED 3/25/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/25/58 | |
| 22c. NAME OF CEMETERY OR CREMATORIALY St. Aloysius | | 22d. LOCATION (City, town, or county) (State) Leonardtown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md. | | ADDRESS | |
| | | 24a. REC'D BY REGISTRAR DATE MAR 27 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Alv. Beach | |

BY THE STATE OF CALIFORNIA
DEPARTMENT OF REVENUE AND TAXES

BUREAU V.

MAR 27 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03748

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | |
|--|--|---|---|---|---|--|--------------------------------------|----------------------|---------------------|----------------------------|
| 1 11 | | PLACE OF DEATH a. COUNTY St. Mary's | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | b. COUNTY St. Mary's | | | | | |
| 78 I | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown | c. LENGTH OF STAY IN lb 5 hrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1 Box 271 Lexington Park | | | | | | |
| | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 3. 3. | | NAME OF DECEASED (Type or print) John Bernard | First John | Middle Bernard | Last Thompson | 4. DATE OF DEATH March | Month | Day 5, | Year 1958 | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1, 1896 | 9. AGE (In years last birthday) 62 yrs. | IF UNDER 1 YEAR Months 5 | IF UNDER 24 HRS. Days 5 | Hours 1 | Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME Joseph Aloysius Thompson | | 14. MOTHER'S MAIDEN NAME Cora Latham | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Teresa Mary Thompson | | Address Rt. 1 Lexington Pk. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX | | DUE TO Cerebral hemorrhage | | DUE TO Hypertension | | TIME BETWEEN ONSET AND DEATH 1 day | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { | | (b) | | (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. — 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | | 20f. (City or town) — | | (County) — | (State) — | |
| 21. I certify that I attended the deceased from 2/5 , 19 55 , to 2/5 , 19 58 , that I last saw the deceased alive on 2/5 , 19 55 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Julian S. Lane | | ADDRESS (Street, city, or town, state) 317 Great Mill Rd., Lexington Pk. Md. | | | | | | | | DATE SIGNED 1958 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/8/58 | | 22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart | | 22d. LOCATION (City, town, or county) Bushwood, Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley | | ADDRESS Leonardtown, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 10 '58 | | 24b. REGISTRAR'S SIGNATURE Albertine | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

| | | | |
|--|---|--|-----------------------|
| DECEASED'S NAME | AGE | SEX | CAUSE OF DEATH |
| EDWARD J. KELLY | 51 | MALE | CHRONIC HEART DISEASE |
| ADDRESS | STREET | CITY | STATE |
| 101 E. BELMONT | APT. 202 | BALTIMORE | MARYLAND |
| NAME AND ADDRESS OF DOCTOR | NAME AND ADDRESS OF HOSPITAL | NAME AND ADDRESS OF FUNERAL HOME | |
| DR. RICHARD L. COOPER 101 E. BELMONT | HOSPITAL OF THE GOOD SHEPHERD 101 E. BELMONT | WILLIAMS FUNERAL HOME 101 E. BELMONT | |
| NAME AND ADDRESS OF POLICE STATION | NAME AND ADDRESS OF MORTUARY | NAME AND ADDRESS OF CEMETERY | |
| BALTIMORE POLICE STATION 101 E. BELMONT | WILLIAMS FUNERAL HOME 101 E. BELMONT | WILLIAMS CEMETERY 101 E. BELMONT | |
| NAME AND ADDRESS OF FUNERAL HOME | NAME AND ADDRESS OF CEMETERY | NAME AND ADDRESS OF POLICE STATION | |
| WILLIAMS FUNERAL HOME 101 E. BELMONT | WILLIAMS CEMETERY 101 E. BELMONT | BALTIMORE POLICE STATION 101 E. BELMONT | |
| RECEIVED BY | | | |
| BUREAU X-5 | | | |
| MAR 10 1958 | | | |